Wenatchee Valley Medical Center

Policy & Procedure # 2042

TITLE: **COMPASSIONATE CARE PROGRAM (WVMC Financial Assistance Program)**

Approved By: David L. Weber, MD Chairman, Board of Directors

Implementation Date: June 1997 Review/Revision Date: 5/1999, 5/8/01, 7/2004, 8/8/05, 12/15/2006

POLICY: It is the Policy of Wenatchee Valley Medical Center (WVMC) that we administer a Compassionate Care Program in order to provide discounted or free medical services to low income or indigent patients (as identified in WAC 246-453-040) who meet the established eligibility requirements.

PROCEDURES: All persons shall be eligible to participate in the Compassionate Care Program without discrimination on the basis of race, color, sex, national origin, creed, disability, age, sexual preference, religious preference or any other grounds unrelated to an individual's need for the service. Applicants with an annualized family income below 300% of the HSA poverty guidelines, adjusted for family size, shall qualify for the compassionate care discount according to the guidelines stated below.

1. When the Business Office Supervisor or Compassionate Care Coordinator is informed of a possible candidate for the compassionate care program, he/she shall make preliminary determination of eligibility at the time of initial treatment or as soon as notified. All documentation must be completed before a final determination of eligibility is made.

2. Patients who feel they may be eligible for the Compassionate Care Program should complete an application form and submit it to the Business Office or Patient Services.

3. The applicant must provide at least one of the following documents as verification of their income:
   a. A "W-2" withholding statement
   b. Paystub(s)
   c. Most recent federal income tax return
   d. Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance
   e. Forms approving or denying unemployment compensation
   f. Written statements from employers or welfare agencies

g. If the applicant is unable to provide any of the previous items, a written statement from the applicant is considered sufficient for making a final determination of eligibility for classification as an indigent person

4. The patient/applicant may be requested to complete the application process for public assistance (Welfare) and must present the Welfare Determination Notice prior to the final determination of eligibility.

5. All insurance or third party payment sources must be exhausted prior to final determination. (All insurance or third party payments made directly to the patient, for Medical Center charges, must be submitted to the Medical Center.)

6. All private pay collection activity will cease once an application for compassionate care is received and for as long as it is under review, provided the applicant is cooperative with the medical center's efforts to reach an initial determination of eligibility. Collection of any third party coverage may continue.

7. Failure to reasonably complete the appropriate application procedure is sufficient grounds for the medical center to initiate collection efforts directed at the patient (WAC 246-453-020).

8. All applications that pertain to both hospital and physician charges will be reviewed by at least one representative from the Business Office (Business Office Supervisor or Business Office Manager) and one representative from Patient Services (Compassionate Care Coordinator or Patient Services Manager) in order to apply the same discount to the patient.

9. An applicant whose family income is less than 300% of the federal poverty standard, adjusted for family size, shall have their charges that are not covered by insurance or other third party payment sources reduced according to the following schedule (in accordance with WAC 246-453-050):

    a. No insured or uninsured patient with the income under 100% of the federal poverty level is required to pay for care.
    b. No insured or uninsured patient with an annual income under 200% of the federal poverty level is required to pay more than the estimated cost of there care. (Cost is the charge times the hospital's average cost-to-charge ratio.)
    c. No uninsured patient with an annual income under 300 percent of the federal poverty level is required to pay more then 130% of the estimated cost of their care. (Cost is the charge multiplied by the hospital's average cost-to-charge ratio)

10. The resulting patient responsibility may be further adjusted by one of the above appropriate personnel after taking into consideration the individual financial circumstances of the applicant (in accordance with WAC 246-453-050).

11. If the application is denied, the Business Office or Patient Services will note the patient's account as to the reason.

12. Appeals for denied applications might be filed with the Director of Finance at Wenatchee Valley Medical Center, P O Box 56, Wenatchee, WA 98807-0056 within 30 days of the denial notification.

    a. The medical center will not refer the account to an outside collection agency within the first 14 days of the denial letter, giving the patient an opportunity to file an appeal. If no appeal has been filed within that time, collection efforts may be initiated.

    b. If an appeal is filed within the 30 day time period, collection activity will cease until the appeal is finalized.

Hospital Service - Specific Guidelines:

1. All applications pertaining only to hospital charges will be reviewed by the Business Office Supervisor and/or Business Office Manager who shall approve or deny the application and notify the applicant (in writing) within 14 days after the completed application is filed (in accordance with WAC 246-453-050). If denied, the letter must include the reason for the denial and notification of the appeal process.

2. If the application is approved and the patient has made any payments on the account previously, those payments shall be refunded to the patient within 30 days of achieving the compassionate care designation (in accordance with WAC 246-453-020).

3. The applicant's financial obligation for hospital services, which remains after the application of this discount schedule, may be payable in monthly installments over a reasonable period of time, without interest or late fees, as negotiated between the medical center and the applicant (in accordance with WAC 246-453-050).

Physician Service – Specific Guidelines:

1. All applications pertaining only to physician services will be reviewed by the Compassionate Care Coordinator and/or Patient Services Manager who shall approve or deny the application and notify the applicant (in writing) within 14 days after the completed application is filed. If denied, the letter must include the reason for the denial and notification of the appeal process.

2. The applicant's financial obligation for physician services, which remains after the application of this sliding fee schedule, may be payable in monthly installments over a reasonable period of time, as negotiated between the medical center and the applicant.